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APPLICATION NO.	FILING DATE	FIRST NAMED INVENTOR	ATTORNEY DOCKET NO.	CONFIRMATION NO.
10/730,680	12/08/2003	Nicole Barvian	PC20508A	5708
28880	7590	10/11/2005	EXAMINER	
WARNER-LAMBERT COMPANY			HABTE, KAHSAI	
2800 PLYMOUTH RD			ART UNIT	
ANN ARBOR, MI 48105			PAPER NUMBER	

1624

DATE MAILED: 10/11/2005

Please find below and/or attached an Office communication concerning this application or proceeding.

# Office Action Summary

Application No.

10/730,680

Applicant(s)

BARVIAN ET AL.

Examiner

Kahsay Habte, Ph. D.

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-- The MAILING DATE of this communication appears on the cover sheet with the correspondence address --

## Period for Reply

A SHORTENED STATUTORY PERIOD FOR REPLY IS SET TO EXPIRE 3 MONTH(S) OR THIRTY (30) DAYS, WHICHEVER IS LONGER, FROM THE MAILING DATE OF THIS COMMUNICATION.

- Extensions of time may be available under the provisions of 37 CFR 1.136(a). In no event, however, may a reply be timely filed after SIX (6) MONTHS from the mailing date of this communication.
- If NO period for reply is specified above, the maximum statutory period will apply and will expire SIX (6) MONTHS from the mailing date of this communication.
- Failure to reply within the set or extended period for reply will, by statute, cause the application to become ABANDONED (35 U.S.C. § 133). Any reply received by the Office later than three months after the mailing date of this communication, even if timely filed, may reduce any earned patent term adjustment. See 37 CFR 1.704(b).

## Status

- 1) ☒ Responsive to communication(s) filed on 12 September 2005.
- 2a) ☐ This action is **FINAL**. 2b) ☒ This action is non-final.
- 3) ☐ Since this application is in condition for allowance except for formal matters, prosecution as to the merits is closed in accordance with the practice under *Ex parte Quayle*, 1935 C.D. 11, 453 O.G. 213.

## Disposition of Claims

- 4) ☒ Claim(s) 1-31 is/are pending in the application.
- 4a) Of the above claim(s) 12-14 and 22 is/are withdrawn from consideration.
- 5) ☐ Claim(s) \_\_\_\_\_ is/are allowed.
- 6) ☒ Claim(s) 23-28 is/are rejected.
- 7) ☒ Claim(s) 1-11, 15-21 and 29-31 is/are objected to.
- 8) ☐ Claim(s) \_\_\_\_\_ are subject to restriction and/or election requirement.

## Application Papers

- 9) ☐ The specification is objected to by the Examiner.
- 10) ☐ The drawing(s) filed on \_\_\_\_\_ is/are: a) ☐ accepted or b) ☐ objected to by the Examiner.  
Applicant may not request that any objection to the drawing(s) be held in abeyance. See 37 CFR 1.85(a).  
Replacement drawing sheet(s) including the correction is required if the drawing(s) is objected to. See 37 CFR 1.121(d).
- 11) ☐ The oath or declaration is objected to by the Examiner. Note the attached Office Action or form PTO-152.

## Priority under 35 U.S.C. § 119

- 12) ☐ Acknowledgment is made of a claim for foreign priority under 35 U.S.C. § 119(a)-(d) or (f).
- a) ☐ All b) ☐ Some \* c) ☐ None of:
- ☐ Certified copies of the priority documents have been received.
  - ☐ Certified copies of the priority documents have been received in Application No. \_\_\_\_\_.
  - ☐ Copies of the certified copies of the priority documents have been received in this National Stage application from the International Bureau (PCT Rule 17.2(a)).

\* See the attached detailed Office action for a list of the certified copies not received.

## Attachment(s)

- 1) ☒ Notice of References Cited (PTO-892)
- 2) ☐ Notice of Draftsperson's Patent Drawing Review (PTO-948)
- 3) ☒ Information Disclosure Statement(s) (PTO-1449 or PTO/SB/08)  
Paper No(s)/Mail Date 5/20, 5/6&3/8 2004.
- 4) ☐ Interview Summary (PTO-413)  
Paper No(s)/Mail Date. \_\_\_\_\_.
- 5) ☐ Notice of Informal Patent Application (PTO-152)
- 6) ☐ Other: \_\_\_\_\_.

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**DETAILED ACTION**

1. Claims 1-31 are pending in this application.

***Election/Restriction***

2. Applicant's election of Group I (Claims 1-11, 15-21 and 23-31) in the reply filed on 9/12/2005 is acknowledged. Because applicant did not distinctly and specifically point out the supposed errors in the restriction requirement, the election has been treated as an election without traverse (MPEP § 818.03(a)).
3. The claims are drawn to multiple inventions for reasons set forth in the restriction requirement. The claims are examined only to the extent that they read on the elected invention. Cancellation of the non-elected subject matter is recommended in response to this Office Action.

***Information Disclosure Statement***

4. Applicant's Information Disclosure Statement, filed on 5/20/2004, 5/6/2004 and 3/8/2004 has been acknowledged. Please refer to Applicant's copies of the 1449 submitted herewith.

***Claim Objections***

5. Claim 1 and claims dependent thereon are objected to because of the following informalities: In claim 1, the recitation of the terms "entgegen" and "zusammen" are

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improper since said terms are not in English. Since claims should be written in English, it is recommended that applicants use the notations "E" and "Z" to replace said German terms.

***Claim Rejections - 35 USC § 112***

6. The following is a quotation of the first paragraph of 35 U.S.C. 112:

The specification shall contain a written description of the invention, and of the manner and process of making and using it, in such full, clear, concise, and exact terms as to enable any person skilled in the art to which it pertains, or with which it is most nearly connected, to make and use the same and shall set forth the best mode contemplated by the inventor of carrying out his invention.

Claims 23-26 and 28 are rejected under 35 U.S.C. 112, first paragraph, because the specification, while being enabling for rest of the diseases recited in claims 24, 25, 26 and 28, does not reasonably provide enablement for the treatment of inflammatory disease, autoimmune diseases, cardiovascular disease, stroke, , cancer and respiratory diseases . The specification does not enable any person skilled in the art to which it pertains, or with which it is most nearly connected, to use the invention commensurate in scope with these claims.

Enablement for the scope of "inflammation" generally is not present. For a compound or genus to be effective against inflammation generally is contrary to medical science. Inflammation is a process which can take place in virtually any part of the body. There is a vast range of forms that it can take, causes for the problem, and biochemical pathways that mediate the inflammatory reaction. There is no common mechanism by which all, or even most, inflammations arise. Mediators include bradykinin, serotonin,

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C3a, C5a, histamine, assorted leukotrienes and cytokines, and many, many others.

Accordingly, treatments for inflammation are normally tailored to the particular type of inflammation present, as there is no, and there can be no "magic bullet" against inflammation generally.

Inflammation is the reaction of vascularized tissue to local injury; it is the name given to the stereotyped ways tissues respond to noxious stimuli. These occur in two fundamentally different types. Acute inflammation is the response to recent or continuing injury. The principal features are dilatation and leaking of vessels, and recruitment of circulating neutrophils. Chronic inflammation or "late-phase inflammation" is a response to prolonged problems, orchestrated by T-helper lymphocytes. It may feature recruitment and activation of T- and B-lymphocytes, macrophages, eosinophils, and/or fibroblasts. The hallmark of chronic inflammation is infiltration of tissue with mononuclear inflammatory cells. Granulomas are seen in certain chronic inflammation situations. They are clusters of macrophages which have stuck tightly together, typically to wall something off. Granulomas can form with foreign bodies such as aspirated food, toxocara, silicone injections, and splinters.

Otitis media is an inflammation of the lining of the middle ear and is commonly caused by *Streptococcus pneumoniae* and *Haemophilus influenzae*. Cystitis is an inflammation of the bladder, usually caused by bacteria. Blepharitis is a chronic inflammation of the eyelids that is caused by a staphylococcus. Dacryocystitis is inflammation of the tear sac, and usually occurs after a long-term obstruction of the nasolacrimal duct and is caused by staphylococci or streptococci. Preseptal cellulitis is inflammation of the

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tissues around the eye, and Orbital cellulitis is an inflammatory process involving the layer of tissue that separates the eye itself from the eyelid. These life-threatening infections usually arise from staphylococcus. Hence, these types of inflammations are treated with antibiotics.

Certain types of anti-inflammatory agents, such as non-steroidal anti-inflammatory medications (Ibuprofen and naproxen) along with muscle relaxants can be used in the non-bacterial cases. The above list is by no means complete, but demonstrates the extraordinary breadth of causes, mechanisms and treatment (or lack thereof) for inflammation. It establishes that it is not reasonable to any agent to be able to treat inflammation generally.

The treatment of "autoimmune diseases" generally would be an unprecedented feat. For a compound or genus to be effective against "autoimmune diseases" generally is contrary to medical science. The "autoimmune diseases" are processes which can take place in virtually any part of the body. There is a vast range of forms that it can take, causes for the problem, and biochemical pathways that mediate the inflammatory reaction. There are dozens of such diseases, which have fundamentally different mechanisms and different underlying causes. Known autoimmune disorders include multiple sclerosis, autoimmune uveitis, rheumatoid arthritis, Addison's disease, thyroiditis, atrophic gastritis, myasthenia gravis, idiopathic thrombocytopenic purpura, hemolytic anemia, systemic lupus erythematosus, primary biliary cirrhosis, Wegener's granulomatosis, polyarteritis nodosa, erythema nodosum leprosum, autoimmune uveitis, Guillain-Barré syndrome (GBS), allergic encephalomyelitis, acute necrotizing

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hemorrhagic encephalopathy, idiopathic bilateral progressive sensorineural hearing loss, aplastic anemia, pure red cell anemia, polychondritis, scleroderma, Stevens-Johnson syndrome, idiopathic sprue, lichen planus, Crohn's disease, Graves ophthalmopathy, sarcoidosis, primary biliary cirrhosis, type I diabetes, autoimmune optic neuritis, uveitis posterior, or interstitial lung fibrosis, alopecia, Sjogren's Syndrome, Goodpasture Syndrome, Myasthenia Gravis, inflammatory bowel disease and many more.

There are both chronic and acute "autoimmune diseases", most of which lack satisfactory treatment. The intractability of these disorders is clear evidence that the skill level in this art is low relative to the difficulty of the task. Under such circumstances, it is proper for the PTO to require evidence that such an unprecedented feat has actually been accomplished. The failure of skilled scientists to achieve a goal is substantial evidence that achieving such a goal is beyond the skill of practitioners in that art, *Genentech vs. Novo Nordisk*, 42 USPQ2nd 1001, 1006.

Since no compound has shown clinical efficacy against all autoimmune diseases, thus no *in vivo* or *in vitro* assay could be validated for the identification of such a general agent. Applicants' specification logically must lack such assay data.

In fact, there are four basic mechanisms underlying autoimmune disease: 1. Antibody mediated diseases: a specific antibody exists targeted against a particular antigen (protein), which leads to its destruction and signs of the disease. Examples are: auto-immune mediated hemolytic anemia, where the target is on the surface of the red blood cell; myasthenia gravis where the target is the acetylcholine receptor in the

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neuromuscular junction; hypoadrenocorticism (Addison's) where the targets are the cells of the adrenal gland. 2. Immune-complex-mediated diseases: antibodies are produced against proteins in the body. These combine into large molecules that circulate around the body. In systemic lupus erythematosus (SLE) antibodies are formed against several components in the cell's nucleus (hence the anti-nuclear antibody test (ANA) for SLE). Most notably antibodies are made against the body's double stranded DNA, and form circulating soluble complexes of DNA and antibody, which break down in skin causing an increased sensitivity to ultraviolet light and a variety of signs. As the blood is filtered through the kidneys, the complexes are trapped in the glomeruli and blood vessels, causing the kidney to leak protein - glomerulonephritis. They also cause leakage in other blood vessels, and there may be hemorrhaging, as well as accumulating in synovial fluid and causing signs of arthritis and joint pain. Rheumatoid arthritis results from immune complexes (IgM class antibody called rheumatoid factor) against part of the patient's own immune system (part of its IgG molecules). These form complexes that are deposited in the synovia of the joint spaces causing an inflammatory response, joint swelling, and pain. The collagen and cartilage of the joint breaks down and is eventually replaced by fibrin which fuses the joints - ankylosis. 3. Antibody and T Cell-mediated diseases: T cells are one of two types (the other being B-cells), which mediate immune reactions. Upon exposure to a particular antigen, they become programmed to search for and destroy that particular protein in future. Once a patient has been exposed to an antigen, he will be able to mount a much faster response to it the next time it encounters it. This is the



basis of vaccination. Thyroiditis (autoimmune hypothyroidism) seems to be of mixed etiology. Several target antigens have been identified, including thyroglobulin the major hormone made by the thyroid. Auto-antibodies to antigens in the epithelial cells of the thyroid have also been found. The thyroid becomes invaded by large numbers of T and B cells as well as macrophages, which are cells that engulf and destroy other cell types. T cells specifically programmed for thyroglobulin have been identified. 4. Diseases arising from a deficiency in complement: When an antigen and antibody react they may activate a series of serum enzymes (the complement system) whose end result is either the lysis (breakup) of the antigen molecule or to make it easier for phagocytic cells like the macrophages to destroy it. Patients with deficiencies in enzymes activated early in the complement system develop autoimmune diseases like SLE.

Thus, with such differing mechanisms, it is not logical that a treatment for autoimmune diseases generally can be found.

Cardiovascular diseases embraces a vast array of problems, many of which are contradictory to others. Thus, it covers hypertension and hypotension. It covers various types of arrhythmias; angina pectoris; the thrombotic symptoms of diabetes, atherosclerosis and hyperlipoproteinaemias; ischaemic heart disease including congestive heart failure and myocardial infarction; stroke, and peripheral vascular disorders, such as deep-vein thrombosis and thrombophlebitis percutaneous transluminal coronary angiography (PTCA); elevated blood levels of triglycerides, of

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total cholesterol or of LDL cholesterol; arteriosclerosis, peripheral vascular disease, cerebral vascular disease and pulmonary hypertension, migraine, cardiomyopathy, etc. Not one compound --- let alone a genus of trillions of compounds, could possibly be effective against such disorders generally.

Stroke represents one of the most intractable medical challenges. Stroke is estimated to cause about 15% of deaths, behind only heart disease and cancer. Even those who survive normally suffer from persistent damage, including motor and speech disturbances and/or convulsions. Despite a tremendous effort to resolve these problems, cerebrovascular therapy as so far been limited to trying to prevent further damage in areas on the margins of the ischemic focus, thus trying to maintain adequate perfusion in remaining intact areas, and thereby limit progressive infarction. This is generally done surgically. Standard pharmaceutical treatment, such as antiarrhythmics and antithrombotics don't get at the cause of the stroke or the damage caused, but are mostly done to insure adequate cardiac functioning.

Effective acute drug treatment of the stroke itself has so far proved to be beyond the reach of medical science. Major efforts have certainly been pressed in the area of neuroprotective therapeutics. Those studied have included use of Ca antagonists such as Levemopamil and flunarizine, to suppress neuronal calcium influx; NMDA antagonists (both competitive, such as APV and CPP, and non-competitive such as chlorpromazine, ifenprodil and Mg salts) as well as AMPA and kainate antagonists to block post-ischemic receptor-operated calcium channels; attempts to block arachidonic acid cascade or elimination of its metabolic products with agents such as lipogenase

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inhibitors and thromboxane; use of free oxygen radical scavengers such as superoxide dismutase, alpha-tocopherol, or allopurinol to inhibit the lipid peroxidation that damages cell membranes, which may indirectly help prevent intracellular calcium overload; anti-edema agents such as corticosteroids; use of 5-HT<sub>1A</sub> receptor agonists to suppress 5-HT concentrations in the hippocampal extracellular space; use of CRF receptor antagonists to inhibit excitotoxic brain damage; use of serotonin 1A agonists such as ipsapirone, or adenosine modulators such as vinpocetine, to stimulate adenosine, which may act as a protective agent by hyperpolarizing the postsynaptic neuron; use of platelet aggregation inhibitors such as prostacycline and ticlopidine, and other approaches as well.

Despite this vast outpouring of research, the skill level in this art is sufficiently low relative to the difficulty of the task that obtaining a neuroprotective treatment of stroke was, as of the filing date, not yet possible. Hence, accomplishing such a goal involves more than routine experimentation. As evidence for this, there is cited Chalmers (TiPS Vol 17, pages 166-172 April 1996), which states flatly on page 170 that, "At present, there are no effective neuroprotective agents that can clinically ameliorate the effects of stroke in humans." For example, Pentoxifylline has been one of the most intensely studied, with dozens of studies published on its properties. It appears to have a wide variety of effects on leucocytes, erythrocytes, neutrophils, plasma fibrinogen levels. These result in a wide-ranging ability to increase blood flow, resulting in effectiveness in some vascular disorders, especially intermittent claudication. Research with different administration methods, or different subcategories of stroke may well result in the

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discovery of how to get this drug to work, but the slowness and difficulty of this research shows clearly that this involves undue, not routine experimentation. Applicants' compounds have been subjected to far less study.

The claim sets forth the treatment of cancer generally. However, there never has been a compound capable of treating cancer generally. There are compounds that treat a range of cancers, but no one has ever been able to figure out how to get a compound to be effective against cancer generally, or even a majority of cancers. Thus, the existence of such a "silver bullet" is contrary to our present understanding in oncology. Even the most broadly effective antitumor agents are only effective against a small fraction of the vast number of different cancers known. This is true in part because cancers arise from a wide variety of sources, such as viruses (e.g. EBV, HHV-8, and HTLV-1), exposure to chemicals such as tobacco tars, genetic disorders, ionizing radiation, and a wide variety of failures of the body's cell growth regulatory mechanisms. Different types of cancers affect different organs and have different methods of growth and harm to the body, and different vulnerabilities. Thus, it is beyond the skill of oncologists today to get an agent to be effective against cancers generally, evidence that the level of skill in this art is low relative to the difficulty of such a task.

When the best efforts have failed to achieve a goal, it is reasonable for the PTO to require evidence that such a goal has been accomplished, *In re Ferens*, 163 USPQ 609. The failure of skilled scientists to achieve a goal is substantial evidence that

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achieving such a goal is beyond the skill of practitioners in that art, *Genentech vs Novo Nordisk*, 42 USPQ2nd 1001, 1006.

There has been claimed the treatment of respiratory disease in general. The scope of respiratory disease that applicants intend to claim is very broad. The origin and nature of respiratory diseases differ one from the other. It can be shown that there are many types of respiratory diseases. For example, the following are common types of respiratory disorders:

- ARDS (acute respiratory distress syndrome)

- Asthma

- Lung Embolism and Infarction

- Cor Pulmonale

- Pneumothorax

- Pulmonary Alveolar Proteinosis

- Respiratory Distress Syndrome

- Bronchopulmonary Dysplasia

- Pneumothorax in Newborns

- Respiratory Infections, such as TB, Pneumonia

- Cystic Fibrosis

- Shortness of Breath (Dyspnea)

- Hypersensitivity Diseases

- Croup

- Pneumoconiosis

- Asbestos-Related Lung Disease

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Lung cancers

In terms of respiratory diseases, the skill level in the art is completely varied. It ranges from areas where the skill level is high, as in asthma, to ARDS, where the skill level is so low that there is no effective pharmacological treatment.

***Claim Rejections - 35 USC § 112***

7. The following is a quotation of the second paragraph of 35 U.S.C. 112:

The specification shall conclude with one or more claims particularly pointing out and distinctly claiming the subject matter which the applicant regards as his invention.

Claims 23-28 are rejected under 35 U.S.C. 112, second paragraph, as being indefinite for failing to particularly point out and distinctly claim the subject matter which applicant regards as the invention:

a. In claims 23-28, the term "PI3K-mediated" is indefinite and broad. What is covered by the term "PI3K" and what is not? According to the specification, PI3Ks are family of lipid kinases. There are several classes of PI3Ks (e.g. PI3K $\alpha$ , PI3K $\beta$ , PI3K $\delta$ , PI3K $\gamma$ ) and isoforms that are implicated in different types of activities in the body. What type of classes of PI3K is not covered?

b. In claim 23, it is recited a method of treatment for PI3K-mediated disorder or condition. The scope of claim 23 is unknown. Which diseases are these? Determining

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whether a given disease responds or does not respond to such mediator will surely involve undue experimentation. Suppose that a given inhibitor X when administered to a patient with Disease D does not obtain a response. Does one then conclude that Disease D does not fall within this claim? Keep in mind that:

A. It may be that the next patient will respond. It is quite common for pharmaceuticals to work only with some people, not all. Thus, how many need to be tested?

B. It may be that the wrong dosage or dosage regimen was employed. It is quite common for pharmaceuticals to work at one dosage, but not at another which is significantly higher or lower. Furthermore, the dosage regimen may be vital --- should the drug be given e.g. once a day, or four times in divided dosages? Thus, how many dosages and dosage regimens must be tried before one is certain that this pharmaceutical won't affect Disease D?

C. It may be that X simply isn't potent enough for Disease D, but that another inhibitor Y is potent enough, so that D really does fall within the claim. Thus, how many different mediators must be tried before one concludes that D doesn't fall within the claim?

D. Conversely, if D responds to Y but not to X, can one really conclude that D falls within the claim? It may be that the X result is giving the accurate answer, and that the success of Y arises from some other unknown property which Y is capable of. Thus, when mixed results are obtained, how many more pharmaceuticals need be tested?

E. Finally, suppose that X really will work, but only when combined with Z.

There are for example, agents in the antiviral and anticancer technology which are not themselves effective, but the disease will respond when the agents are combined with something else.

F. In addition, literally speaking, any disorder can be treated with any drug, although the treatment might not be successful. Assuming that "successful treatment" is what is intended, what criterion is to be used? If one person in 10 responds to a given drug, does that mean that the disease is treatable? One in 100? 1,000? 10,000?

As a result, determining the true scope of the claim will involve extensive and potentially open-ended research. Without it, one skilled in the art cannot determine the actual scope of the claim. Hence, the claim is indefinite.

### ***Conclusion***

8. Any inquiry concerning this communication or earlier communications from the examiner should be directed to Kahsay Habte, Ph. D. whose telephone number is (571) 272-0667. The examiner can normally be reached on M-F (9.00AM- 5:30PM).

If attempts to reach the examiner by telephone are unsuccessful, the examiner's supervisor, James Wilson can be reached at (571) 272-0661. The fax phone number for the organization where this application or proceeding is assigned is (571)-273-8300.

Information regarding the status of an application may be obtained from the Patent Application Information Retrieval (PAIR) system. Status information for



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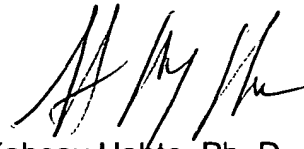
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A handwritten signature in black ink, appearing to read 'Kahsay Habte'.

Kahsay Habte, Ph. D.  
Patent Examiner  
Art Unit 1624

KH

October 6, 2005